

# EXHIBIT D

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**UNITED STATES SECURITIES AND EXCHANGE COMMISSION**  
**Washington, D.C. 20549**

**Form 10-K**

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES  
EXCHANGE ACT OF 1934**  
For the fiscal year ended December 31, 2010

OR

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES  
EXCHANGE ACT OF 1934**  
For the transition period from to

Commission file number 001-34746

**Accretive Health, Inc.**

*(Exact name of registrant as specified in its charter)*

**Delaware**  
*(State or other jurisdiction of  
incorporation or organization)*  
**401 North Michigan Avenue  
Suite 2700  
Chicago, Illinois**  
*(Address of principal executive offices)*

**02-0698101**  
*(I.R.S. Employer  
Identification No.)*  
**60611**  
*(Zip Code)*

**Registrant's telephone number, including area code**  
**(312) 324-7820**

**Securities registered pursuant to Section 12(b) of the Act:**  
**Common Stock, \$0.01 par value**

**Securities registered pursuant to Section 12(g) of the Act:**  
**None**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate website, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§ 232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes ☐ No ☐

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K. ☒

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☐ Non-accelerated filer ☒ Smaller reporting company ☐  
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

Aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based on the last sale price for such stock on June 30, 2010: \$375,694,705.

The number of shares outstanding of each of the registrant's classes of common stock, as of February 28, 2011:

Common Stock, \$0.01 par value 95,126,464

Portions of the registrant's definitive Proxy Statement for its 2011 Annual Meeting of Stockholders are incorporated by reference into Part III of this Annual Report.



## ACCRETIVE HEALTH, INC.

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This Annual Report on Form 10-K contains forward-looking statements, within the meaning of the federal securities laws, that involve substantial risks and uncertainties. All statements, other than statements of historical facts, included in this Annual Report on Form 10-K regarding our strategy, future operations, future financial position, future revenue, projected costs, prospects, plans, objectives of management and expected market growth are forward-looking statements. The words “anticipate”, “believe”, “estimate”, “expect”, “intend”, “may”, “plan”, “predict”, “project”, “will”, “would” and similar expressions are intended to identify forward-looking statements, although not all forward-looking statements contain these identifying words. These forward-looking statements include, among other things, statements about:

- our ability to attract and retain customers;
- our financial performance;
- the advantages of our solutions as compared to those of others;
- our new quality and total cost of care service initiative;
- our ability to establish and maintain intellectual property rights;
- our ability to retain and hire necessary employees and appropriately staff our operations;
- our estimates regarding capital requirements and needs for additional financing; and
- our projected contracted annual revenue run rate.

We may not actually achieve the plans, intentions or expectations disclosed in our forward-looking statements, and you should not place undue reliance on our forward-looking statements. Actual results or events could differ materially from the plans, intentions and expectations disclosed in the forward-looking statements we make. We have included important factors in the cautionary statements included in this Annual Report, particularly in the “Risk Factors” section, that could cause actual results or events to differ materially from the forward-looking statements that we make. Our forward-looking statements do not reflect the potential impact of any future acquisitions, mergers, dispositions, joint ventures or investments we may make.

You should read this Annual Report and the documents that we have filed as exhibits to the Annual Report completely and with the understanding that our actual future results may be materially different from what we expect. We do not assume any obligation to update any forward-looking statements, whether as a result of new information, future events or otherwise, except as required by law.

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*Unless the context indicates otherwise, references in this Annual Report to "Accretive Health," "Accretive," the "Company," "we," "our," and "us" mean Accretive Health, Inc. and its subsidiaries.*

**Item 1. Business****Overview**

Accretive Health is a leading provider of services that help healthcare providers generate sustainable improvements in their operating margins and healthcare quality while also improving patient, physician and staff satisfaction. Our core service offering helps U.S. healthcare providers to more efficiently manage their revenue cycles, which encompass patient registration, insurance and benefit verification, medical treatment documentation and coding, bill preparation and collections. Our quality and total cost of care service offering, introduced in 2010, can enable healthcare providers to effectively manage the health of a defined patient population, which we believe is a future direction of the manner in which healthcare services will be delivered in the United States.

At December 31, 2010 we provided our revenue cycle service offering to 26 customers representing 66 hospitals as well as physician billing organizations associated with several of these customers. At December 31, 2010 we provided our quality and total cost of care solution to one customer representing seven hospitals and 42 clinics.

Our integrated revenue cycle technology and services offering spans the entire revenue cycle. We help our revenue cycle customers increase the portion of the maximum potential patient revenue they receive while reducing total revenue cycle costs. Our quality and total cost of care solution can help our customers identify the individuals who are most likely to experience an adverse health event and, as a result, incur high healthcare costs in the coming year. This data allows providers to focus greater efforts on managing these patients within and across the delivery system, as well as at home.

Our customers typically are multi-hospital systems, including faith-based or community healthcare systems, academic medical centers and independent ambulatory clinics, and their affiliated physician practice groups. We seek to develop strategic, long-term relationships with our customers and focus on providers that we believe understand the value of our operating model and have demonstrated success in both clinical and operational outcomes.

Grounded in sophisticated analytics, our revenue cycle solution spans our customers' entire revenue cycle. This helps set us apart from competing services, which we believe address only a portion of the revenue cycle. We are not a traditional outsourcing company focused solely on cost reductions. Through the implementation of our distinctive operating model that includes people, processes and technology, customers for our revenue cycle management services can generate significant and sustainable revenue cycle improvements. Our service offerings are adaptable to the evolution of the healthcare regulatory environment, technology standards and market trends, and require no up-front cash investment by our customers.

To implement our solutions, we assume full responsibility for the management and cost of a customer's revenue cycle or quality and total cost of care operations and supplement the customer's existing staff with seasoned Accretive Health personnel. We collaborate with our customers' employees with the objective of educating and empowering them so that over time they can deliver improved results using the proprietary technology included in our applications. Once implemented, our technology applications, processes and services are deeply embedded in a hospital's day-to-day operations. We and our customers share financial gains resulting from our solutions, which directly aligns our objectives and interests with those of our customers. Both we and our customers benefit — on a contractually agreed-upon basis — from revenue increases and cost savings realized by the customers as a result of our services. We believe that, over time, this alignment of interests fosters greater innovation and incentivizes us to improve our customers' operations.

The revenue cycle operations of a typical hospital, physician or other healthcare provider often fail to capture and collect the total amounts contractually owed to it from third-party payors and patients for medical

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services rendered, leading to significant bad debt write-offs, uncompensated care, payment denials by payors and corresponding administrative write-offs, as well as lost revenue for missed charges. Fitch Ratings estimates that in 2008 and 2009, uncompensated care (including bad debt write-offs, charity care and uninsured discounts) averaged 19% and 20% of net patient revenue at U.S. hospitals, respectively, and that this percentage increased to an average of 21.3% in the first three quarters of 2010. We generally deliver operating margin improvements to our customers through a combination of improvements in collections, which we refer to as net revenue yield; charge capture, which involves ensuring that all charges for medical treatment are included in the associated bill; and revenue cycle cost reductions. Our customers have historically achieved significant net revenue yield improvements within 18 to 24 months of implementing our operating model, with customers subject to mature managed service contracts typically realizing 400 to 600 basis points in yield improvements in the third or fourth contract year. All of a customer's yield improvements during the period we are providing services are attributed to our solution because we assume full responsibility for the management of the customer's revenue cycle. Our methodology for measuring yield improvements excludes the impact of external factors such as changes in reimbursement rates from payors, the expansion of existing services or addition of new services, volume increases and acquisitions of hospitals or physician practices, which may impact net revenue but are not considered changes to net revenue yield. Improvements in charge capture and collections are typically attributable to reduced payment denials by payors, identification of additional items that can be billed to payors based on the actual procedures performed, identification of insurance for a higher percentage of otherwise uninsured patients, and improved collections of patient balances after insurance. Revenue cycle cost reductions are typically achieved through operating efficiencies, including streamlining work flow, automating processes and centralizing vendor activities. Specific sources of margin improvement vary among customers.

Our quality and total cost of care solution can help our customers identify the individuals who are most likely to experience an adverse health event and, as a result, incur high healthcare costs in the coming year. This data allows providers to focus greater efforts on managing these patients within and across the delivery system, as well as at home. We assist our customers in capturing a share of the reductions in healthcare costs by helping them negotiate contracts with third-party payors that provide an equitable sharing of the savings in total medical costs among the payor and provider. We will receive a share of the provider community cost savings for our role in providing the technology infrastructure and for managing the care coordination process.

We have developed and refined our solutions based in part on information, processes and management experience garnered through working with many of the largest and most prestigious hospitals and healthcare systems in the United States. We seek to embed our technology, personnel, know-how and culture within each customer's revenue cycle or population health management activities with the expectation that we will serve as the customer's on-site operational manager beyond the managed service contract's initial term, which typically ranges from four to five years. To date, we have experienced a contract renewal rate of 100% (excluding exploratory new service offerings, a consensual termination following a change of control and a customer reorganization). Coupled with the long-term nature of our managed service contracts and the fixed nature of the base fees under each contract, our historical renewal experience provides a core source of recurring revenue.

Our net services revenue consists primarily of base fees and incentive fees. We receive base fees for managing our customers' revenue cycle or quality and total cost of care operations, net of any cost savings we share with those customers. Incentive fees represent our portion of the increase in our customers' revenue resulting from our services. We generate a portion of our operating margin as a result of the difference between the fixed base fees and the variable costs of the operations that we manage. Incentive fees contribute directly to operating margin, thus significantly impacting our profitability. We monitor each customer's revenue cycle or quality and total cost of care performance through periodic operating reviews. A customer's revenue improvements and cost savings generally increase over time as we deploy additional programs and as the programs we implement become more effective, which in turn provides visibility into our future revenue and profitability. In 2010, for example, approximately 87% of our net services revenue, and nearly all of our net income, was derived from customer contracts that were in place as of January 1, 2010. In 2010, we had net services revenue of \$606.3 million, representing growth of 19% over 2009 and a compound annual growth

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rate of 39% since January 1, 2006. We recognized no revenue from our quality and total cost of care offering in 2010. In addition, we were profitable for the years ended December 31, 2007, 2008, 2009 and 2010, and our profitability increased in each of those years. See "Management's Discussion and Analysis of Financial Condition and Results of Operations — Seasonality" for a discussion of seasonality in our business.

### **Market Opportunity**

We believe that current macroeconomic conditions will continue to impose financial pressure on healthcare providers and will increase the importance of managing their revenue cycles and quality and total cost of care activities effectively and efficiently. We estimate that the domestic market opportunity for our revenue cycle services exceeds \$50 billion, calculated as 5% (the approximate percentage of a representative hospital system's total annual revenue paid to us for our revenue cycle management services at contract maturity, which is generally reached in three and one-half to four years) of approximately \$1,020 billion in total annual revenue for services and goods that our revenue cycle solution addresses, which is estimated as follows:

- the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services, or CMS, estimates that in 2009 total revenue for hospitals was \$759 billion, total revenue for home healthcare services was \$68 billion and total revenue from sales of durable and non-durable medical equipment was \$78 billion; and
- we target the largest physician organizations, which we believe represent \$115 billion, or approximately 20% of CMS's estimate of total physician and clinical revenue in 2009.

According to the CMS, expenditures for hospitals and physician and clinical services are expected to increase between 2009 and 2018 at annual rates of approximately 6.4% and 5.4%, respectively. Population growth, longer life expectancy, the increasing prevalence of chronic illnesses (such as diabetes and obesity) and the over-utilization of certain healthcare services is expected to put increasing pressure on hospitals, physicians and other healthcare providers to operate more efficiently. American Hospital Association (AHA) surveys indicate that approximately 43% of hospitals had a negative operating margin during the first quarter of 2009. Additionally, AHA reports that approximately 73% of hospitals had reduced capital spending in the first quarter of 2010, the latest period reported. As the scope of healthcare services expands and financial pressures mount, hospitals are demanding both greater effectiveness and improved efficiency in the management of their revenue cycle operations. We believe that efficient management of the revenue cycle and collection of the full amount of payments due for patient services are among the most critical challenges facing healthcare providers today.

We believe that the inability of healthcare providers to capture and collect the total amounts owed to them for patient services is caused by the following trends:

- **Complexity of Revenue Cycle Management.** At most hospitals, there is a lack of standardization across operating practices, payor and patient payment methodologies, data management processes and billing systems. In general, after a patient receives healthcare services, the hospital must coordinate payment with two or more parties, including third-party insurance companies, federal and state government payors, private charities and individual payors. Hospitals also face a growing population of uninsured patients, whom healthcare providers have an ethical and legal obligation to treat.
- **Lack of Integrated Systems and Processes.** Although interrelated, the individual steps in the revenue cycle are not operationally integrated across revenue cycle departments at many hospitals. Multiple tasks and milestones must be completed properly by personnel in various departments before a hospital or physician can be reimbursed for patient services. It is often difficult for a single organization to acquire and coordinate all the knowledge and experience necessary to identify and eliminate inefficiencies within the revenue cycle. Even if all steps are performed flawlessly, the time required to receive full payment for services creates long billing cycles. With frequent changes in the reimbursement rules imposed by third-party payors, the billing and collections cycle often is not timely and error-free, further lengthening the time before payment is actually received by the healthcare provider.

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- ***Increasing Patient Financial Responsibility for Healthcare Services.*** Hospitals are being forced to adapt to the need for direct-to-patient billing and collections capabilities as patients bear payment responsibility for an increasing portion of healthcare costs. Hospitals have traditionally focused on collecting payments from insurance companies and from state and federal payors, and typically are less familiar with the processes necessary to collect payments from patients at the point of service, including the use of alternative payment options. Patient billing is often confusing and payment instructions are often unclear. Moreover, hospitals generally do not utilize consumer segmentation techniques to formulate effective revenue collection approaches to patients. As a result, hospitals generally write-off a high percentage of patient-owed bills, resulting in increases in bad debt and uncompensated care.
- ***Outdated Systems and Insufficient Resources to Upgrade Them.*** Many hospitals suffer from operating inefficiencies caused by outdated technology, increasingly complex billing requirements, a general lack of standardization of process and information flow, costly in-house services that could be more economically outsourced, and an increasingly stringent regulatory environment. Hospitals often lack the breadth and depth of data available to payors, and this lack of information may contribute to the filing of less accurate claims with third-party insurance payors and unfavorable resolutions of disputed claims. In addition, the endowments of most hospitals have significantly declined, motivating them to make their revenue cycle operations more efficient.

In addition to the above trends, we believe that the federal healthcare reform legislation that was enacted in March 2010 may create new business opportunities for us by increasing the need for services such as those that we provide. For example, reduced reimbursement for some healthcare providers may cause these healthcare providers to turn to outsourcing to extract more out of their existing revenue cycles, and value and quality-based reimbursement incentives created by the legislation could generate more interest in our quality and total cost of care service offerings.

### **The Accretive Health Revenue Cycle Solutions**

Our revenue cycle solution is intended to address the full spectrum of revenue cycle operational issues faced by healthcare providers, including:

- the increasingly complex and challenging payor environment;
- a lack of fully integrated end-to-end revenue cycle management expertise;
- the consequences of increasing patient responsibility for their healthcare costs;
- the difficulty and associated expense of a single organization acquiring and coordinating the knowledge and experience necessary to efficiently manage the revenue cycle;
- ongoing attrition of revenue cycle staff; and
- frequent patient confusion and frustration with financial obligations and billing.

The revenue cycle operations of a typical hospital, physician or other healthcare provider fail to capture and collect the total amounts owed to them from third-party payors and patients for medical services rendered, leading to significant bad debt write-offs, uncompensated care, payment denials by payors and corresponding administrative write-offs, as well as lost revenue for missed charges. Fitch Ratings estimates that in 2008 and 2009, uncompensated care (including bad debt write-offs, charity care and uninsured discounts) averaged 19% and 20% of net patient revenue at U.S. hospitals, respectively, and that this percentage increased to an average of 21.3% in the first three quarters of 2010.

We deliver operating margin improvements to our customers through a combination of improvements in net revenue yield, charge capture and revenue cycle cost reductions. Improvements in charge capture and collections are typically attributable to reduced payment denials by payors, identification of additional items that can be billed to payors based on the actual procedures performed, identification of insurance for a higher percentage of otherwise uninsured patients, and improved collections of patient balances after insurance. Revenue cycle cost reductions are typically achieved through operating efficiencies, including streamlining

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work flow, automating processes and centralizing vendor activities. Specific sources of margin improvement vary among customers.

Our customers have historically achieved significant net revenue yield improvements within 18 to 24 months of implementing our operating model, with customers operating under mature managed service contracts typically realizing 400 to 600 basis points in yield improvements in the third or fourth contract year. During the assessment phase of the customer relationship, we identify specific areas for improvement in net revenue yield and begin implementation immediately upon execution of a managed service contract. While improvements in net revenue yield generally represent the majority of a customer's operating margin improvement, we generally are able to deliver additional margin improvement through revenue cycle cost reductions. Because our managed service contracts align our interests with those of our customers, we have been able, over time, to improve our margins along with those of our customers.

We believe that our proprietary and integrated technology, management experience and well-developed processes are enhanced by the knowledge and experience we gain working with a wide range of customers and improve with each payor reimbursement or patient pay transaction. Our proprietary technology applications include workflow automation and direct payor connection capabilities that enable revenue cycle staff to focus on problem accounts rather than on manual tasks, such as searching payor websites for insurance and benefits verification for all patients. We employ technology that identifies and isolates specific cases requiring review or action, using the same interface for all users, to automate a host of tasks that otherwise can consume a significant amount of staff time. We use real-time feedback from our customers to improve the functionality and performance of our technology and processes and incorporate these improvements into our service offerings on a regular basis. We strive to apply operational excellence throughout the entire revenue cycle.

We adapt our solution to the hospital's organizational structure in order to minimize disruption to existing staff and to make our services transparent to both patients and physicians. The experience and knowledge of the senior management personnel we provide to our customers can improve the performance of their in-house revenue cycle staff. Our objective is to improve the operating performance of our customers, thus generating incentive fees for ourselves, by:

- ***Improving Net Revenue Yield.*** We help our customers improve their net revenue yield. Through the use of our proprietary technologies and methodologies, we precisely calculate each customer's improvement in net revenue yield. This calculation compares the customer's actual cash collections for a given instance of care to the maximum potential cash receipts that the customer should have received from the instance of care, which we refer to as the best possible net compliant revenue. We aggregate these calculations for all instances of care and compare the result to the aggregate calculation for the year before we began to provide our services to the customer. We receive a share of each customer's improvement in net revenue yield.
- ***Increasing Charge Capture.*** We help our customers increase their charge capture by implementing optimization techniques and related processes. We utilize sophisticated analytics and artificial intelligence software to help improve the accuracy of claims filings and the resolution of disputed claims from third-party insurance payors. We also overlay a range of capabilities designed to reduce missed charges, improve the clinical/reimbursement interface and produce bills that comply with third-party payor requirements and applicable healthcare regulations.
- ***Making Revenue Cycle Operations More Efficient.*** We help our customers make their revenue cycle operations more efficient by implementing advanced technologies, streamlining operations, avoiding unnecessary re-work and improving quality. We also can reduce the costs of third-party services, such as Medicaid eligibility review, by transferring the work to our own internal operations. For some customers, we are able to reduce operating costs further by transferring selected internal operations to our centralized shared services centers located in the United States and India.

We employ a variety of techniques intended to achieve this objective:

- ***Gathering Complete Patient and Payor Information.*** We focus on gathering complete patient information and validating insurance coverage and benefits so the services can be recorded and billed

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to the appropriate parties. For scheduled healthcare services, we educate the patient as to his or her potential financial responsibilities before receiving care. Our systems maintain an automated electronic scorecard, which measures the efficiency of up-front data capture, billing and collections throughout the life cycle of any given patient account. These scorecards are analyzed in the aggregate, and the results are used to help improve work flow processes and operational decisions for our customers. Our analyses of data measured by our systems show that hospitals employing our services have increased the percentage of non-emergency in-patient admissions with complete information profiles to more than 90%, enabling fewer billing delays, increased charge capture and reduced billing cycles.

- ***Improving Claims Filing and Third-Party Payor Collections.*** Based on our customers' experience, and on industry sources, hospitals typically do not collect 100% of the amounts they are contractually owed by insurance companies. Through our proprietary technology and process expertise, we identify, for each patient encounter, the amount our customer should receive from a payor if the applicable contract with the payor and patient policies are followed. Over time, we compare these amounts with the actual cash collected to help identify which payors, types of medical treatments and patients represent various levels of payment risk for a customer. Using proprietary algorithms and analytics, we consider actual reimbursement patterns to predict the payment risk associated with a customer's claims to its payors, and we then direct increased attention and time to the riskiest accounts. Our experience is that this approach significantly increases the likelihood that a customer will be reimbursed the amounts it is contractually owed for providing its services.
- ***Identifying Alternative Payment Sources.*** We use various methods to find payment sources for uninsured patients and reimbursement for services not covered by third-party insurance. Our patient financial screening technology and methodologies often identify federal, state or private grant sources to help pay for healthcare services. These techniques are designed to ease the financial burden on uninsured or underinsured patients and increase the percentage of patient bills that are actually paid. After a typical implementation period, we have been able to help our customers find a third-party payment source for approximately 85% of all admitted patients who identified themselves as uninsured.
- ***Employing Proprietary Technology and Algorithms.*** Our service offerings employ a variety of proprietary data analytics and predictive modeling algorithms. For example, we identify patient accounts with financial risk by applying data mining techniques to the data we have collected. Our systems are designed to streamline work processes through the use of proprietary algorithms that focus revenue cycle staff effort on those accounts deemed to have the greatest potential for improving net revenue yield or charge capture. We frequently adjust our proprietary predictive algorithms to reflect changes in payor and patient behavior based upon the knowledge we glean from our entire customer base. As new customers are added and payor and patient behavior changes, the information we use to create our algorithms expands, increasing the accuracy and value of those algorithms. We rely upon a combination of patent, trademark, copyright and trade secret law and contractual terms and conditions to protect our intellectual property rights. We hold one U.S. patent and have filed six additional U.S. patent applications covering key innovations utilized in our revenue cycle management solution.
- ***Using Analytical Capabilities and Operational Excellence.*** We draw on the experience that we have gained from working with many of the best healthcare provider systems in the United States to train hospital staffs about new and innovative revenue cycle management practices. We employ extensive analytical analyses to identify specific weaknesses in business processes. We also strive to achieve operational excellence and to foster an overall culture of leading by example. As a result, our on-site management teams have seen marked shifts in the behaviors of hospital administrative staff, including enthusiasm for setting daily and weekly goals, participation in daily half-hour gatherings to track results achieved during the day, and improved adherence to our standard operating procedures.

In addition, we help our customers increase their revenue cycle efficiency by implementing improved practices, advanced data management technology, streamlining work flow processes and outsourcing aspects of their revenue cycle operations. For example, services that can be shared across our customers, such as patient scheduling and pre-registration, medical transcription and patient financial services, can be performed in our

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shared services centers in the United States and India. By leveraging the economies of scale and experience of our shared services centers, we believe that we offer our customers better quality services at a lower cost. For those customers opting not to participate in our shared services program, we can help reduce costs by migrating services such as Medicaid eligibility, medical transcription and collections from external vendors to our internal staff.

### **Our Strategy**

Our goal is to become the preferred provider-of-choice for revenue cycle and quality and total cost of care services in the U.S. healthcare industry. Since our inception, we have worked with some of the largest and most prestigious healthcare systems in the United States, such as Ascension Health, the Henry Ford Health System and the Dartmouth-Hitchcock Medical Center. Going forward, our goal is to continue to expand the scope of our services to hospitals within our existing customers' systems as well as to leverage our strong relationships with reference customers to continue to attract business from new customers. Key elements of our strategy include the following:

- ***Delivering Tangible, Long-Term Results by Providing Services that Span the Entire Revenue Cycle.*** Our revenue cycle solution is designed to help our customers achieve sustainable economic value through improvements in operating margins. Improvements in our customers' operating margins in turn provide recurring revenues for us. Our technology and services are deeply integrated across the customer's entire revenue cycle, whereas most competitive offerings address a narrower portion of the revenue cycle. Our offering alleviates the need to purchase services from multiple sources, potentially saving customers time, money and integration challenges in their efforts to improve their revenue cycle activities.
- ***Continuing to Develop Innovative Approaches to Increase the Collection Rate on Patient-Owed Obligations.*** We have developed and continue to design creative approaches intended to increase net revenue yields on patient-owed obligations. These processes include direct communications with payors to establish patient pay amounts (after insurance and taking into account deductibles) and status, contract modeling applications to provide patients with accurate updates on the portion of an outstanding balance for which they are personally responsible, and the provision of prior balance data and payment alternatives to patients at the point of service. We also use consumer behavior modeling and conduct trending analyses for collections, and we offer patients a variety of payment methods.
- ***Enhancing and Developing Proprietary Algorithms to Identify Potential Errors and to Make Process Corrections.*** Even as patients begin to assume responsibility for a greater portion of the cost of medical services, healthcare providers continue to rely upon third-party payors for the majority of medical reimbursements. To help improve revenue collection rates and timing for claims owed by payors, we have developed proprietary algorithms to assess risk and the resulting treatment of claims. Our methodology is designed to enable nearly 100% of outstanding claims to be reviewed, prioritized and pursued. We believe that our focus on collecting revenue from a broader range of outstanding claims and reducing the average time to collection differentiates our revenue cycle management services. An additional proprietary algorithm that distinguishes our services from others is incorporated in our charge capture application that identifies potential lost charges. In instances where our customers have been using other third-party applications, we routinely identify multiple additional lost charges.
- ***Expanding Our Revenue Cycle Shared Services Program.*** Our revenue cycle shared services program, which includes patient scheduling and pre-registration, medical transcription and patient financial services, is structured to reduce a hospital's overhead costs while providing services of comparable or higher quality. Expansion of our shared services program is potentially advantageous for both our customers and us, as we both benefit from greater savings attributable to economies of scale and improvements in net revenue yield. We believe that continuing to transition customers to our shared services will help us achieve our targeted improvements in customer operating margins. We introduced the shared services program in 2008, and we continue to see interest in this offering from both new and existing customers. As of February 28, 2011, approximately 39% of our customers for whom we have

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provided revenue cycle management services for at least one year participate in our shared services program.

- ***Hiring, Training and Retaining Our Personnel.*** Our solutions were developed by what we believe to be the best personnel available in the market. In order to grow our business and solidify our competitive position, we need to continue to hire, train and retain very talented team members who demonstrate a strong focus on outstanding customer service. Employee recruitment is a priority for us because we believe that our long-term growth is limited more by the availability of top talent than by constraints in market demand for our solutions. We seek an ongoing influx of new personnel at all levels so that we have adequate staffing to pursue and accept new customer opportunities. We also make substantial ongoing investments in employee training, including our “operator academy” and “revenue cycle academy” which enable us to educate all new employees regarding our operating models and related processes and technology.
- ***Continuing to Diversify Our Customer Base.*** In October 2004, Ascension Health became our founding customer. While Ascension Health is our largest customer and we expect to continue to expand our presence within Ascension Health’s network of affiliated hospitals, we are focusing our marketing efforts primarily on other healthcare providers and expect to continue to diversify our customer base. In the year ended December 31, 2010 compared to the year ended December 31, 2009, our net services revenue from customers not affiliated with Ascension Health grew by 47.6%, while our net services revenue from hospitals affiliated with Ascension Health was essentially unchanged. As a result, the percentage of our total net services revenue attributable to hospitals affiliated with Ascension Health declined from 88.7% in the year ended December 31, 2006 to 50.7% in the year ended December 31, 2010. Between January 1, 2008 and December 31, 2010, approximately 76% of the increase in our PCARRR was attributable to customers not affiliated with Ascension Health.
- ***Developing Enhanced Service Offerings that Offer Long-Term Opportunities.*** We intend to continue to introduce new services that draw upon our core competencies and that we believe will be attractive to our target customers. In considering new services, we look for market opportunities that we believe present low barriers to entry, require limited incremental cost and present significant growth opportunities. For example, in 2009 we began providing physician advisory services to help hospitals classify emergency room patient admissions to maximize compliant revenue. In 2010, we introduced our quality and total cost of care offering focused on increasing the quality of healthcare through incentive payments to the hospitals and their affiliated physicians. We also plan to selectively pursue acquisitions that will enable us to broaden our service offerings.

## **Segments**

The information about our business segment set forth below should be read together with our consolidated financial statements and related notes included elsewhere in this Annual Report on Form 10-K. All of the Company’s significant operations are organized around the single business of providing end-to-end management services of revenue cycle operations for U.S.-based hospitals and other medical providers. Accordingly, the Company has only one operating and reporting segment. All of the Company’s net services revenue and trade accounts receivable are derived from healthcare providers domiciled in the United States. See Note 3 to our consolidated financial statements contained elsewhere in this Annual Report on Form 10-K for net services revenue for each of the last three fiscal years.

## **Our Services**

### ***Core Service Offering — Revenue Cycle Management***

Our core revenue cycle services offering consists of comprehensive, integrated technology and revenue cycle management services. We assume full responsibility for the management and cost of the customer’s complete revenue cycle operations in exchange for a base fee and the opportunity to earn incentive fees. To implement our solution, we supplement the customer’s existing revenue cycle management and staff with seasoned Accretive Health revenue cycle leaders, subject matter experts and staff, and connect our proprietary

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technology and analytical applications to the hospital's existing technology systems. Our employees that we add to the hospital's revenue cycle team typically have significant experience in healthcare management, revenue cycle operations, technology, quality control and other management disciplines. In addition to implementing revenue enhancement procedures, we help our customers reduce their revenue cycle costs by implementing improved practices, advanced data management technology and more efficient processes, as well as outsourcing aspects of their revenue cycle operations. We seek to adapt our solution to the hospital's organizational structure in order to minimize disruption to existing staff and to make our services transparent to both patients and physicians.

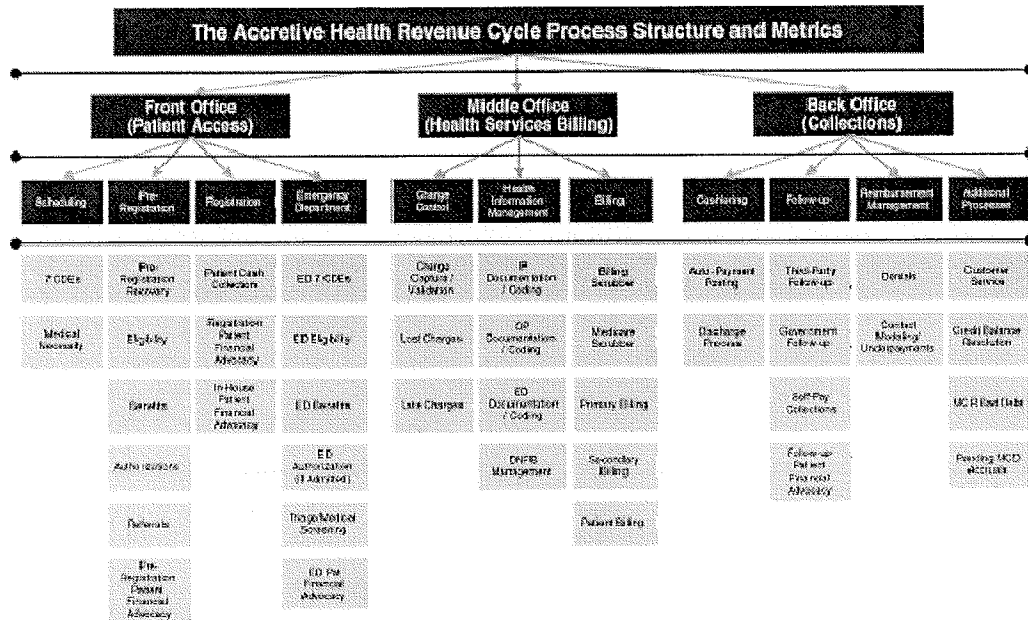
We believe that our revenue cycle management solution offers our customers a number of strategic, financial and operational benefits:

- ***Operating Management.*** We assign highly-trained management teams to each customer site to facilitate technology implementation, provide hands-on training to existing hospital employees and guide staff toward achievable performance goals.
- ***Technology Improvements.*** We integrate our proprietary technology with a hospital's transaction systems to help improve claims collections and realize operating efficiencies. By using a web interface to layer our applications on top of a hospital's existing software, we can bring our capabilities online in a timely manner without requiring any up-front hardware investment by customers.
- ***Standardized Operating Model.*** We offer our customers a revenue cycle operating model that has delivered tangible financial benefits. Our standard implementation techniques are designed to enable us to install our operating model in a timely manner and consistently at customer sites. We utilize a uniform set of key performance indicators to drive and assess the revenue cycle operations of our customers. Our senior operational leaders monitor each customer's revenue cycle performance through ten to twelve operating reviews each year.
- ***Multi-Industry Revenue Process Experience.*** Our personnel have years of prior work experience advising customers on revenue process management issues in complex industries. We have combined this experience with healthcare industry innovative practices and operational excellence to form the foundation of our service offerings. We believe that the depth and breadth of our knowledge of healthcare and non-healthcare revenue cycle management help differentiate us from our competitors.
- ***Shared Services.*** We offer customers the opportunity to realize operating efficiencies by outsourcing certain revenue tasks and responsibilities to shared facilities that we operate. By allowing multiple, unrelated hospitals to utilize the same set of resources for key revenue cycle tasks, our shared services capability provides opportunities to reduce the operating costs of our customers. We have been able to achieve meaningful margin improvements for the customers that utilize our shared services.

Our solution spans a hospital's entire revenue cycle. We deploy our proprietary technology and management experience at each key point in the revenue cycle. As part of our solution, we make targeted changes in the hospital's processes designed to improve its revenue cycle operations. We also implement cost-reduction programs, including the use of our shared services centers for customers who choose to participate

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and, for other customers, by moving services such as Medicaid eligibility, transcription and collections from external vendors to our internal staff.



**Front Office (Patient Access).** A hospital's front office revenue cycle operations typically consist of scheduling, pre-registration, registration and collection of patient co-payments. Complete and accurate information gathering at this stage is critical to a hospital's ability to collect revenue from the patient and third-party payors after healthcare services are provided.

Our AHtoAccess application, an integrated suite of proprietary patient admission applications, is designed to minimize downstream collections issues by standardizing up-front patient information gathering through direct connections between the customer and each of its third-party payors and automated workflow navigation of authorization and referral requirements. Our AHtoAccess application is used by our on-site management teams and hospital employees to handle a variety of front office tasks, including:

- verification of patient contact information, which improves accuracy of recording patient admissions data in the hospital's patient accounting system;
- real-time validation of coverage and benefits for insured patients, which allows up-front assessment of each patient's ability to pay;
- screening of self-pay patients for alternative coverage solutions, which helps identify payment sources including long-term payment plans and charity or government-sponsored coverage for uninsured or underinsured patients; and
- up-front calculation of patient pay residuals, which facilitates accurate and timely communication and collection of residual payment obligations and any outstanding patient balances from previous services.

**Middle Office (Health Services Billing).** Once treatment has been provided to a patient, a hospital's middle office revenue cycle operations typically consist of transcribing physicians' dictated records of patient care and related diagnoses, assigning treatment codes so that bills may be generated and consolidating all patient information into a single patient file. Our solution provides opportunities to improve revenue yield attributable to the middle office by enabling a customer to properly bill all appropriate charges, reduce payment denials by payors based upon inaccurate or incomplete billing or untimely filing, and improve the accuracy and comprehensiveness of patient and billing information to enable bills to be issued in a timely and efficient manner.

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We deploy several proprietary software applications in the middle office. Our AHtoCharge automated variance detection application is used to identify missing charges in patient bills and to detect coding errors in patient records. In addition to the use of proprietary technology, we enhance a hospital's revenue cycle operations in the middle office with our:

- in-house nurse auditors, who review the accuracy of treatments, diagnoses and charges in patient records and follow-up with hospital revenue cycle staff so that the bills may be updated and sent out within the normal billing cycle; and
- on-staff physicians, who help hospital case managers properly code emergency department patients during their transition from "observation" to "in-patient" status, to improve accurate and appropriate billing to payors.

**Back Office (Collections).** A hospital's back office revenue cycle operations typically consist of bill creation and submission, follow-up to resolve unpaid or underpaid claims and re-submit incomplete claims, the collection of amounts due from patients and the application of cash payments to outstanding balances. At this stage of the revenue cycle, efficiency and data accuracy are critical to increasing the hospital's collections from all responsible parties in a timely manner, and reducing the hospital's bad debt expense. Our solution is designed to improve revenue yield attributable to the back office by enabling a customer to:

- decrease the time required for bill creation and submission;
- increase the percentage of claims receiving maximum allowable reimbursement from payors;
- find alternative payment sources for unpaid and underpaid claims with both third-party payors and patients; and
- reduce contractual write-offs to provide an accurate record of outstanding charges.

We deploy a number of proprietary applications in the back office:

- **Yield-Based Follow Up.** Our Yield-Based Follow Up application enables us to pursue reimbursement for claims based on risk scoring and detection as established by our proprietary algorithms.
- **Medical Financial Solutions.** Our Medical Financial Solutions application uses proprietary algorithms to assess a patient's propensity to pay and determines follow-up actions structured to allow higher yields with lower collections effort.
- **Retro Eligibility.** Our Retro Eligibility application continually searches for insurance coverage for each patient visit, even after treatment has concluded, to determine whether uninsured patients are eligible for some form of insurance coverage.
- **AHtoContract.** Our AHtoContract application utilizes proprietary modeling and analytics to calculate the aggregate reimbursement due to the hospital from third-party payors and patients for a given patient treatment.
- **Underpayments.** Our Underpayments application employs payor remittance data and contract models to determine whether a payor has reimbursed less than its contracted amount for a specific claim and enables the hospital's back office staff to resolve these situations directly with payors.
- **AHtoPost.** Our AHtoPost application is used by our shared services centers to centralize the task of posting cash payments to customers' patient accounting systems.

## **Emerging Service Offerings**

**Quality and Total Cost of Care.** Introduced in 2010, our quality and total cost of care service offering consists of a combination of people, processes and technology that enable our customers to effectively manage the health of a defined patient population. Through this offering, our customers have the ability to improve the quality of care, enhance the patient and physician experience and ultimately reduce the total cost of the population's healthcare.

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We believe that there is a significant market for this type of service offering. Many studies have found that U.S. healthcare costs are the highest in the developed world without a corresponding increase in overall population healthcare quality. We believe that the following trends are among the reasons that healthcare costs continue to rise at rates that exceed the increase in the consumer price index:

- ***Improperly Aligned Incentives.*** Healthcare providers currently have little or no financial incentive to make the necessary people, processes or technology investments to optimize care delivery that results in a lower total cost of care for their patients. The prevailing fee-for-service payment system reimburses healthcare providers for the amount or number of services provided, establishing an incentive for more healthcare services to be provided.
- ***Non-Coordination of Care Across Healthcare Settings.*** Due to the fragmented nature of the healthcare provider market, the prevailing fee-for-service reimbursement system and a lack of coordination resources, healthcare providers find it challenging to optimize healthcare delivery across the full continuum of providers and services. This challenge is magnified for patients with complex medical conditions that visit multiple providers. Studies have shown that a small portion of medically complex patients are accountable for a disproportionate share of total healthcare costs.
- ***Lack of Integrated Technology Systems and Information Sharing Processes.*** Due to the improperly aligned incentives and fragmented delivery system, providers generally lack an integrated technology system that projects the acuity and healthcare needs of patients, communicates and assigns various tasks to other providers, and measures the results of each patient encounter to maximize overall patient quality and cost of care. There are significant costs associated with developing this type of technology, and providers generally lack the financial resources to develop this functionality.

Furthermore, we believe that management of the health of a defined patient population is a future direction of the manner in which healthcare services will be delivered in the United States. For example, the federal healthcare reform legislation that was enacted in March 2010 encourages healthcare providers to experiment with alternative methods to reduce healthcare spending while improving the quality of care. The legislation specifically directs the CMS to establish a structure whereby combinations of hospitals, physicians and other providers can become "accountable care organizations" for patients covered by Medicare and Medicaid. Our quality and total cost of care service offering positions us to continue providing a significant service offering to healthcare providers in the event that healthcare delivery evolves away from the traditional fee-for-service payment system and toward accountable care organizations or other initiatives that reduce demand for our revenue cycle management services.

We believe that our technology and service infrastructure, which we provide with no initial investment by the provider, can facilitate improvements to quality, cost and patient experience by employing sophisticated proprietary algorithms that identify the individuals who are most likely to experience an adverse health event and, as a result, incur high healthcare costs in the coming year. This data allows providers to focus greater efforts on managing these patients within and across the delivery system, as well as at home. The ability of our quality and total cost of care solution to link episodes of care also can help facilitate the re-emergence of the primary care physician as the coordinator of each patient's care. We believe that primary care physicians can drive a significant number of healthcare decisions (excluding personal lifestyle decisions) that have a meaningful impact on efforts to improve clinical outcomes and reduce the cost of healthcare. Primary care physicians and other providers can use our extensive database and knowledge of available medical resources to create individualized care plans for all patients. Providers can also use the care coordination resources we deploy when implementing our solution to conduct patient interventions that help ensure that the identified patients are able to adhere to the care plans developed by the physician and patient. Finally, our solution can provide the patient's primary care provider with real-time insight into services being provided across the healthcare delivery system.

By allowing hospitals and physicians to deliver healthcare services to specific patient populations, and focusing on prevention, medical best practices and the use of electronic health records to achieve better outcomes, we believe that our quality and total cost of care solution can enable third-party payors to give providers an incentive to achieve reductions in the total cost of care for the defined patient population while

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maintaining or improving overall medical quality. We assist our customers in capturing a share of the reduction in healthcare costs by helping them negotiate contracts with third-party payors that provide an equitable sharing of the savings in total medical costs among the payor and providers. We receive a share of the provider community cost savings for our role in providing the technology infrastructure and for managing the care coordination process.

We believe that we are well-positioned to deliver this new service offering. Our core management team leading this initiative has a demonstrated track record of implementing processes that are similar in nature to our solution and which brought improvements to quality and healthcare cost reductions to the market. As with revenue cycle operations, we believe that our proprietary and integrated technology, management experience and well-developed processes are enhanced by the knowledge and experience we will gain working with a wide range of customers. Our proprietary technology applications include workflow automation that enable care management staff to expend extra effort on high priority patients, while still being able to monitor all patients. Finally, when a customer adopts both our revenue cycle and quality and total cost of care management solutions, we can leverage the information available in our revenue cycle technology and data platform to enable real-time care management.

The CMS estimates that aggregate healthcare expenditures in the United States were \$2.5 trillion in 2009. Based on the components of these aggregate healthcare expenditures for which we believe our quality and total cost of care services are suitable, we believe that our quality and total cost of care service offering can potentially address approximately \$1.7 trillion of this amount, consisting of the sum of the following CMS estimates for 2009: \$759 billion for hospitals, \$506 billion for physicians and clinics, \$250 billion for prescriptions, \$78 billion for durable and non-durable medical equipment, \$68 billion for home healthcare services and \$67 billion for other professional services. However, as of December 31, 2010 we had only one customer for our quality and total cost of care service offering, and there is no assurance that we will be able to achieve a significant portion of this estimated market opportunity.

To date, all customers for all of our service offerings have been located in the United States. We believe that increasing healthcare costs are a concern for other developed nations and that management of the health of a defined patient population is a cost-effective means to control overall healthcare expenditures. We have received inquiries from government related healthcare providers in other countries about our quality and total cost of care service offering. As a result, we are beginning to evaluate the level of potential interest in this service offering and the methods of delivering this solution to international customers. This process is in a very early stage and there is no assurance that a market for our quality and total cost of care service offering will develop outside of the United States or that we will be able to serve this market efficiently.

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Our quality and total cost of care services offering includes management of the following processes:

Risk Evaluation, Stratification & Coding	Delivery & Access	Care Coordination	Admission Management	Coaching & Education	Analytics & Reporting
<ul style="list-style-type: none"> <li>Health Risk Assessment</li> <li>Accurate claim / medical record documentation</li> <li>Medical and Rx claim review</li> <li>Per patient risk score calculation</li> <li>Best possible revenue code</li> <li>Automated care plans</li> <li>Patient social service determination</li> </ul>	<ul style="list-style-type: none"> <li>Physician Incentive Structure</li> <li>Local PCP leadership and governance structure</li> <li>Comprehensive referral plans</li> <li>Clinical protocol determination</li> <li>Contract sub-specialties</li> <li>Contract ancillary services</li> <li>Community resources</li> <li>Specialist efficiency evaluation</li> </ul>	<ul style="list-style-type: none"> <li>Post-Discharge Follow-up</li> <li>Authorizations</li> <li>Case Management</li> <li>On-boarding</li> <li>Home assessments</li> <li>Referrals and Referral links to PCP</li> <li>Scheduling</li> <li>Medical necessity review</li> <li>Pharmacy Management</li> </ul>	<ul style="list-style-type: none"> <li>Hospitalist program / ED management</li> <li>Daily census -- Acute / Skilled / LTAC</li> <li>Patient review by facility</li> <li>Length of stay management</li> <li>Discharge planning</li> <li>Delivery System re-entry</li> <li>Transitional care</li> </ul>	<ul style="list-style-type: none"> <li>Performance management- Revenue, Cost, Quality, &amp; Service reviews</li> <li>Population-based opportunity reviews</li> <li>Training &amp; education on delivery</li> <li>Benefit / Eligibility</li> <li>Provider service rates</li> </ul>	<ul style="list-style-type: none"> <li>Quality scorecard</li> <li>Pricing / Benefit evaluations</li> <li>Utilization by all healthcare service types</li> <li>P/L by Patient, PCP, Group, Network</li> <li>Benchmarks</li> <li>Peer group analysis</li> <li>Other determinations</li> </ul>
Payer Relationship Management					
People & Technology					

**Physician Advisory Services.** Introduced in 2009, our physician advisory services, or Accretive PAS, offering is focused on assisting hospitals maximize their compliant revenue associated with emergency room visits and similar patient classification issues. Through use of our web-based portal, we provide our customers with concurrent reviews to support the decision whether to classify an emergency department visit as an in-patient or observation case for billing purposes. This proactive case management increases our customer's compliance with CMS policies and reduces their exposure to the risk of having to return previously recorded revenue.

Our Accretive PAS offering is gaining acceptance among hospital management personnel due to increased demands being placed on healthcare providers for precision in their case classification. These increasing demands are the result of continually changing criteria and regulations and the increasingly formalized audit processes being instituted by government and commercial payors. These events are leading providers to institute more formalized processes so that they can better defend themselves when facing payment recovery audits conducted on behalf of third-party payors. Our Accretive PAS offering is billed on a case by case basis or a monthly retainer based on the anticipated volume of cases at each customer hospital.

According to CMS policies, the decision to classify a patient as an in-patient or observation case is based on complex medical judgment that can only be made after the physician has considered a number of factors including the patient's medical history and current medical needs, the type of facilities available to outpatients and inpatients, the severity of signs and symptoms and the medical predictability of adverse events. Using our secure web portal, hospital customers transmit pertinent data about the case at hand to our physicians who then leverage our proprietary diagnosis protocols and the extensive information within our knowledge database to reach an informed classification judgment. Each day our physicians communicate directly with the physicians at our customer hospitals. We also periodically meet with our customers at their facilities to discuss potential process and clinical documentation improvements. We believe that this physician to physician contact and our adherence to our predetermined service levels concerning the timeliness of responses help distinguish our service offering from competitive offerings.

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### Customers

#### *Our Customers*

Customers for our service offerings typically are multi-hospital systems, including faith-based or community healthcare systems, academic medical centers and independent clinics, and the physician practice groups affiliated with those systems. Our service offerings are best-suited for healthcare organizations in which substantial improvements can be realized through the full implementation of our solutions. We seek to develop strategic, long-term relationships with our customers and focus on providers that we believe understand the value of our operating model and have demonstrated success in both the provision of healthcare services and the ability to achieve financial and operational results. In October 2004, Ascension Health became our founding customer. While Ascension Health is still our largest customer and we expect to continue to expand our presence beyond the hospitals we currently service within Ascension Health's network, we are focusing our marketing efforts primarily on other healthcare providers and expect to continue to diversify our customer base. As of December 31, 2010, we provided our integrated revenue cycle service offerings to 26 customers representing 66 hospitals, as well as physicians' billing organizations associated with several of these customers. As of December 31, 2010 we provided our quality and total cost of care service offering to one of these customers representing seven hospitals and 42 clinics.

We target eight market segments in the United States for our integrated revenue cycle service offering:

- ***Academic Medical Centers and Ambulatory Clinics.*** Academic medical centers and ambulatory clinics, including related physician practices, represent approximately \$132 billion in annual net patient revenue. This market segment offers attractive opportunities for us because of the significant size and patient volume of academic medical centers and ambulatory clinics (typically more than \$1 billion each in net patient revenue) and the fragmented revenue cycle management operations of most physician practices. Our customers in this market segment include the Dartmouth-Hitchcock Medical Center and the Henry Ford Health System.
- ***Catholic Community Healthcare Systems.*** Catholic community healthcare systems represented our initial target market segment and remain a primary focus for us. Catholic community healthcare systems manage approximately \$68 billion in annual net patient revenue. Ascension Health is the nation's largest Catholic and largest non-profit healthcare system, with a network of 78 hospitals and related healthcare facilities located in 20 states and the District of Columbia. We serve a number of hospitals and regional healthcare systems affiliated with Ascension Health.
- ***Other Faith-Based Community Healthcare Systems.*** Drawing on our experience with the Catholic community healthcare system market, we also target the market for other faith-based community healthcare systems. Healthcare systems affiliated with other religious faiths manage approximately \$46 billion in annual net patient revenue. We serve several regional healthcare systems in this market segment.
- ***Not-for-Profit Community Hospitals.*** There are nearly 2,000 not-for-profit community hospitals, with a variety of affiliations that are not faith-based. Not-for-profit community hospitals, including integrated delivery networks, manage approximately \$265 billion in annual net patient revenue. Fairview Health Services, which is an integrated delivery network, is one of our customers in this market segment, with seven hospitals served, and is our inaugural quality and total cost of care customer.
- ***Physicians' Billing Organizations.*** Large physicians' billing organizations represent more than \$115 billion in annual net patient revenue. Our customer work in this market includes the billing activities involving several hundred physicians at the Dartmouth-Hitchcock Medical Center and the Henry Ford Health System.
- ***For-Profit Hospital Systems.*** For-profit hospital systems manage approximately \$101 billion in annual net patient revenue. This sector, although smaller than the not-for-profit sector, still represents a significant target market segment for our revenue cycle services. We currently serve one for-profit

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hospital as the result of the acquisition of a formerly non-profit hospital by a for-profit company in 2009.

- **Government-Owned Hospitals.** Based on industry sources, each major metropolitan area in the United States has at least one large municipal or city-owned hospital system. We believe that this market segment represents approximately \$111 billion in annual net patient revenue. We do not currently have any customers in this market segment.
- **Home Services and Medical Equipment.** In 2010, we began targeting the home healthcare services and medical equipment providers market, which we believe represents \$80 billion in annual net patient revenue. This market includes both for-profit and not-for-profit companies which work with hospitals and physicians across the United States. We believe that most companies in this market fail to capture and collect a significant portion of the total amounts contractually owed to them due to their highly decentralized customer service and order entry departments and the differences in payor requirements that occur when goods and services are provided in multiple locations.

The six hospital market segments noted above are also targets of our quality and total cost of care offering. We believe that the diversity of our customer base, ranging from not-for-profit community hospitals to large academic medical centers and healthcare systems, demonstrates our ability to adapt and apply our operating model to many different situations.

### *Customer Agreements*

We provide our revenue cycle and quality and total cost of care service offerings pursuant to managed service contracts with our customers. In rendering our services, we must comply with customer policies and procedures regarding charity care, personnel, compliance and risk management as well as applicable federal, state and local laws and regulations. Generally, we are the exclusive provider of revenue cycle or quality and total cost of care services to our customers.

Our contracts are multi-year agreements and vary in length based on the customer. After the initial term of the agreement, our customer contracts automatically renew unless terminated by either party upon prior written notice.

In general, our managed service contracts provide that:

- we assume responsibility for the management and cost of the customer's revenue cycle or population health management operations, including the payroll and benefit costs associated with the customer's employees conducting activities within our contracted services, and the agreements and costs associated with the related third-party services;
- we are required to staff a sufficient number of our own employees on each customer's premises and the technology necessary to implement and manage our services;
- in general, the customer pays us base fees equal to a specified amount, subject to annual increases under an agreed-upon formula, and incentive fees based on achieving agreed-upon financial benchmarks;
- the parties provide representations and indemnities to each other; and
- the contracts are subject to termination by either party in the event of a material breach which is not cured by the breaching party.

### **Sales and Marketing**

Our new business opportunities have historically been generated through high-level industry contacts of members of our senior management team and board of directors and positive references from existing customers. As we have grown, we have added senior sales executives and adopted a more institutional approach to sales and marketing that relies on systematic relationship building by a team of 10 senior sales executives. Our sales process generally begins by engaging senior executives of the prospective hospital or

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healthcare system, typically followed by our assessment of the prospect's existing revenue cycle operations and a review of the findings. We employ a standardized managed service contract that is designed to streamline the contract process and support a collaborative discussion of revenue cycle operation issues and our proposed working relationship. Our sales process typically requires six to twelve months from the introductory meeting to contract execution.

## **Technology**

### *Technology Development*

Our technology development organization operates out of various facilities in the United States and India. Our technology is developed in-house by Accretive Health employees, although at times we may supplement our technology development team with independent contractors, all of whom have assigned any resulting intellectual property rights to us. We use a rapid application development methodology in which new functionality and enhancements are released on a 30-day cycle, and minor functionality or "patch" work is released on a seven-day cycle. Based upon this schedule, we release approximately eleven technology offerings with new functionalities each year across each of the four principal portions of our customer-facing applications. All customer sites run the same base set of code. We use a beta-testing environment to develop and test new technology offerings at one or more customers, while keeping the rest of our customers on production-level code.

Our applications are deployed on a consistent architecture based upon an industry-standard Microsoft SQL\*Server database and a "DotNetNuke" open source application architecture. This architecture provides a common framework for development, which in turn simplifies the development process and offers a common interface for end users. We believe the consistent look and feel of our applications allows our customers and staff to begin using ongoing enhancements to our software suite quickly and easily.

We devote substantial resources to our development efforts and plan at a yearly, half-yearly, quarterly and release level. We employ a "value point" scoring system to assess the impact an enhancement will have on net revenue, costs, efficiency and customer satisfaction. The results of this value point system analysis are evaluated in conjunction with our overall corporate goals when making development decisions. In addition to our technology development team, our operations personnel play an integral role in setting technology priorities in support of their objective of keeping our software operating 24 hours a day, 7 days a week.

### *Technology Operations*

Our applications are hosted in data centers located in Alpharetta, Georgia and Salt Lake City, Utah, and our internal financial application suite is hosted in a data center in Minneapolis, Minnesota. These data centers are operated for us by third parties and are SAS-70 compliant. Our development, testing and quality assurance environment is operated from our Alpharetta, Georgia data center, with a separate server room in Chicago, Illinois. We have agreements with our hardware and system software suppliers for support 24 hours a day, 7 days a week. Our operations personnel also use our resources located in our other U.S. facilities and in our India facilities.

Customers use high-speed Internet connections or private network connections to access our business applications. We utilize commercially available hardware and a combination of custom-developed and commercially available software. We designed our primary application in this manner to permit scalable growth. For example, database servers can be added without adding web servers, and vice versa. We believe that this architecture enables us to scale our operations effectively and efficiently.

Our databases and servers are backed-up in full on a weekly basis and undergo incremental back-ups nightly. Databases are also backed-up frequently by automatically shipping log files with accumulated changes to separate sets of back-up servers. In addition to serving as a back-up, these log files update the data in our online analytical processing engine, enabling the data to be more current than if only refreshed overnight. Data and information regarding our customers' patients is encrypted when transmitted over the internet or traveling off-site on portable media such as laptops or backup tapes.

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Customer system access requests are load-balanced across multiple application servers, allowing us to handle additional users on a per-customer basis without application changes. System utilization is monitored for capacity planning purposes.

Our software interacts with our customers' software through a series of real-time and batch interfaces. We do not require changes to the customer's core patient care delivery or financial systems. Instead of installing hardware or software in customer locations or data centers, we specify the information that a customer needs to extract from its existing systems in order to interface with our systems. This methodology enables our systems to operate with many combinations of customer systems, including custom and industry-standard implementations. We have successfully integrated our systems with 15 to 20 year old systems, with package and custom systems, and with major industry-standard products.

When these interfaces are in place, we provide an application suite across the hospital revenue cycle. For our purposes, the revenue cycle starts when a patient registers for future service or arrives at a hospital or clinic for unscheduled service and ends when the hospital has collected all the appropriate revenue from all possible sources. Thus, we provide eligibility, address validation, skip tracing, charge capture, patient and payor follow-up, analytics and tracking, charge master management, contract modeling, contract "what if" analysis, collections and other functions throughout the front office, middle office and back office operations of a customer's revenue cycle.

Because our databases run on industry-standard hardware and software, we are able to use all standard applications to develop, maintain and monitor our solutions. Databases for one or more customers can run on a single database server with disk storage being provided from a shared storage area network (SAN) with physical separation maintained between clients. In the event of a server failure, we have maintenance contracts in place that require the service provider to have the server back on-line in four hours or less, or we move the customer processing to another server. The SAN is configured as a redundant array of inexpensive disks (RAID) and this RAID configuration protects against disk failures having an impact on our operations.

In the event that a combination of events causes a system failure, we typically can isolate the failure to one or a small number of customers. We believe that no combination of failures by our systems can impact a customer's ability to deliver patient care, nor can any such failures prevent accurate accounting of customer finances because accounting functions are maintained on customer systems. In the past twelve months, our up-time has exceeded 99.95% of planned up-time.

Our data centers were designed to withstand many catastrophic events, such as blizzards and hurricanes. To protect against a catastrophic event in which our primary data center is completely destroyed and service cannot be restored within a few days, we store backups of our systems and databases off-site. In the event that we had to move operations to a different data center, we would re-establish operations by provisioning new servers, restoring data from the off-site backups and re-establishing connectivity with our customers' host systems. Because our systems are web-based, no changes would need to be made on customer workstations, and customers would be able to reconnect as our systems became available again.

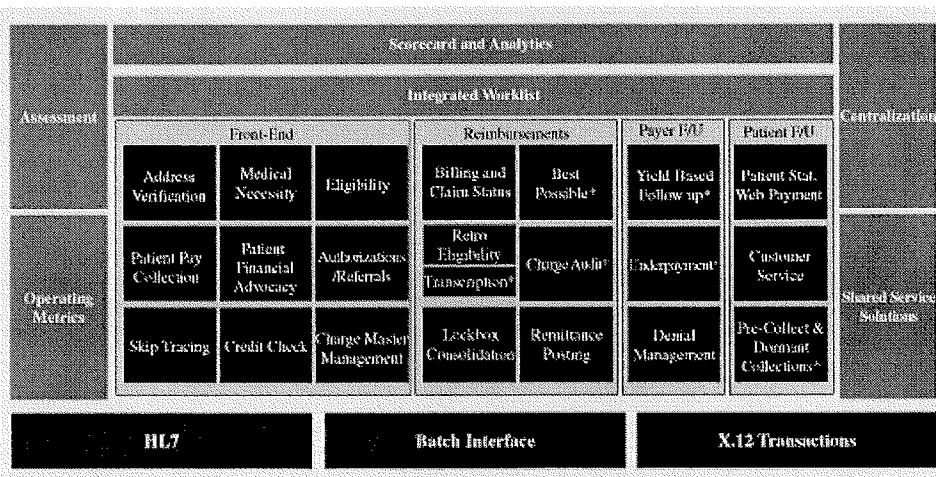
We monitor the response time of our application in a number of ways. We monitor the response time of individual transactions by customer and place monitors inside our operations and at key customer sites to run synthetic transactions that demonstrate our systems' end-to-end responsiveness. Our hosting provider reports on responsiveness server-by-server and identifies potential future capacity issues. In addition, we survey key customers regarding system response time to make sure customer-specific conditions are not impacting performance of our applications.

### **Proprietary Software Suite**

*Revenue Cycle Management.* Our proprietary AHtoAccess software suite is composed of a broad range of integrated functional areas or domains. The "patient access", "improving best possible", "follow-up" and "measurement" domains utilize interdependent design and development paths and are an integral driver of value throughout our customers' entire revenue cycle. These domains correspond to the front office, middle office and back office revenue cycle business processes described above.

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- The “patient access” domain is used during hospital employees’ first interactions with patients, either at the point of service in a hospital or in advance of a hospital visit during our pre-registration process. The domain uses a straightforward, consistent architecture.
- The “improving best possible” domain is designed to facilitate top-line revenue improvements and bottom-line efficiency gains. The domain’s AHtoCharge application is a rules-based engine that, with the oversight of a centralized team of nurse-auditors, automatically analyzes medical billing and coding data to identify inconsistencies that may delay or hinder collections.
- The “follow-up” domain tracks unpaid claims and contacts with insurance companies, government organizations and other payors responsible for outstanding debts for past patient services. The domain also organizes previously unpaid claims using a proprietary risk-based algorithm.
- The “measurement” domain integrates our functional domains by providing real-time metrics and insight into the operation of revenue cycle businesses. This application can be used to generate standard operational reports and allows the end user to review and analyze all of the micro-level data that supports the results found in these reports.



In addition to applications designed for use by our customers, we have developed proprietary software for use in our collections operations and measurement activity. To manage patient follow-up activities and the collection of patient debt, we use a combination of off-the-shelf telephony and campaign management software which analyzes critical data points to determine the optimum approach for collecting outstanding debts. Our measurement system enables a user to generate models for outstanding medical claims related to specific third-party payors and determine the maximum allowed reimbursement, based upon the hospital’s contract with each payor.

*Quality and Total Cost of Care.* Our proprietary AccretiveQ software suite provides the technology infrastructure to enable our customers to have visibility into, and better control of, the full spectrum of services and associated costs for all patients. Our AccretiveQ software consists of two broad domains, “analytics” and “workflow”. The analytics domain provides physicians with on-line analytical processing capabilities so that they can more easily and accurately monitor patient results by grouping patients with similar healthcare attributes, risk scores, demographics and other factors. We also use the analytics domain to monitor the results of individual physicians, physician practices or clinics in their efforts to institute the use of processes that will result in enhanced clinical outcomes with lower total cost of care for the defined patient populations. The workflow domain uses a combination of proprietary algorithms and industry standard applications to prioritize the patients that are most at risk of an adverse health event. The domain then

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automatically assigns the patient to an appropriate care coordinator, assists in developing the patient's care plan, and serves as a tool for scheduling the appropriate care interventions. The workflow solution also monitors variation in care plan activities and the success rate of applying the care plan's parameters.

### **Competition**

While we do not believe any single competitor offers a fully integrated, end-to-end revenue cycle management solution, we face competition from various sources.

The internal revenue cycle management staff of hospitals, who historically have performed the functions addressed by our services, in effect compete with us. Hospitals that previously have made investments in internally developed solutions sometimes choose to continue to rely on their own internal revenue cycle management staff.

We also currently compete with three categories of external participants in the revenue cycle market, most of which focus on small components of the hospital revenue cycle:

- software vendors and other technology-supported revenue cycle management business process outsourcing companies, such as athenahealth and MedAssets;
- traditional consultants, either specialized healthcare consulting firms or healthcare divisions of large accounting firms, such as Deloitte Consulting and Huron Consulting; and
- IT outsourcers, which typically are large, non-healthcare focused business process outsourcing and information technology outsourcing firms, such as Perot Systems and Computer Science Corporation/First Consulting.

These types of external participants also compete with us in the field of quality and total cost of care. In addition, the commercial payor community has historically attempted to provide information or services that are intended to assist providers in reducing the total cost of medical care. They could attempt to develop similar programs again.

We believe that competition for the services we provide is based primarily on the following factors:

- knowledge and understanding of the complex healthcare payment and reimbursement system in the United States;
- a track record of delivering revenue improvements and efficiency gains for hospitals and healthcare systems;
- the ability to deliver a solution that is fully-integrated along each step of a hospital's revenue cycle operations;
- cost-effectiveness, including the breakdown between up-front costs and pay-for-performance incentive compensation;
- reliability, simplicity and flexibility of the technology platform;
- understanding of the healthcare industry's regulatory environment; and
- sufficient infrastructure and financial stability.

We believe that we compete effectively based upon all of these criteria. We also believe that several aspects of our business model differentiate us from our competitors:

- our solutions do not require any up-front cash investment from customers and we do not charge hourly or licensing fees for our services;
- we serve only healthcare providers and do not provide services to third-party payors; and
- we focus on delivering significant and sustainable improvements rather than one-time cost reductions only.

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Nonetheless, we operate in a growing and attractive market with a steady stream of new entrants. Although we believe that there are barriers to replicating our end-to-end revenue cycle solution, we expect competition to intensify in the future. Other companies may develop superior or more economical service offerings that hospitals could find more attractive than our offerings. Moreover, the regulatory landscape may shift in a direction that is more strategically advantageous to existing and future companies.

### **Government Regulation**

The customers we serve are subject to a complex array of federal and state laws and regulations. These laws and regulations may change rapidly, and it is frequently unclear how they apply to our business. We devote significant efforts, through training of personnel and monitoring, to establish and maintain compliance with all regulatory requirements that we believe are applicable to our business and the services we offer.

#### *Government Regulation of Health Information*

**Privacy and Security Regulations.** The Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations that have been issued under it, which we collectively refer to as HIPAA, contain substantial restrictions and requirements with respect to the use and disclosure of individuals' protected health information. HIPAA prohibits a covered entity from using or disclosing an individual's protected health information unless the use or disclosure is authorized by the individual or is specifically required or permitted under HIPAA. Under HIPAA, covered entities must establish administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of electronic protected health information maintained or transmitted by them or by others on their behalf.

HIPAA applies to covered entities, such as healthcare providers that engage in HIPAA-defined standard electronic transactions, health plans and healthcare clearinghouses. In February 2009, HIPAA was amended by the Health Information Technology for Economic and Clinical Health, or HITECH, Act to impose certain of the HIPAA privacy and security requirements directly upon "business associates" that perform functions on behalf of, or provide services to, certain covered entities. Most of our customers are covered entities and we are a business associate to many of those customers under HIPAA as a result of our contractual obligations to perform certain functions on behalf of and provide certain services to those customers. In order to provide customers with services that involve the use or disclosure of protected health information, HIPAA requires our customers to enter into business associate agreements with us so that certain HIPAA requirements would be applied to us as contractual commitments. Such agreements must, among other things, provide adequate written assurances:

- as to how we will use and disclose the protected health information;
- that we will implement reasonable administrative, physical and technical safeguards to protect such information from misuse;
- that we will enter into similar agreements with our agents and subcontractors that have access to the information;
- that we will report security incidents and other inappropriate uses or disclosures of the information; and
- that we will assist the customer with certain of its duties under HIPAA.

**Transaction Requirements.** In addition to privacy and security requirements, HIPAA also requires that certain electronic transactions related to healthcare billing be conducted using prescribed electronic formats. For example, claims for reimbursement that are transmitted electronically to payors must comply with specific formatting standards, and these standards apply whether the payor is a government or a private entity. We are contractually required to structure and provide our services in a way that supports our customers' HIPAA compliance obligations.

**Data Security and Breaches.** In recent years, there have been well-publicized data breach incidents involving the improper dissemination of personal health and other information of individuals, both within and outside of the healthcare industry. Many states have responded to these incidents by enacting laws requiring

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holders of personal information to maintain safeguards and to take certain actions in response to data breach incidents, such as providing prompt notification of the breach to affected individuals and government authorities. In many cases, these laws are limited to electronic data, but states are increasingly enacting or considering stricter and broader requirements. Under the HITECH Act and its implementing regulations, business associates are also required to notify covered entities, which in turn are required to notify affected individuals and government authorities of data security breaches involving unsecured protected health information. In addition, the U.S. Federal Trade Commission, or FTC, has prosecuted some data breach cases as unfair and deceptive acts or practices under the Federal Trade Commission Act. We have implemented and maintain physical, technical and administrative safeguards intended to protect all personal data and have processes in place to assist us in complying with applicable laws and regulations regarding the protection of this data and properly responding to any security incidents.

**State Laws.** In addition to HIPAA, most states have enacted patient confidentiality laws that protect against the unauthorized disclosure of confidential medical information, and many states have adopted or are considering further legislation in this area, including privacy safeguards, security standards and data security breach notification requirements. Such state laws, if more stringent than HIPAA requirements, are not preempted by the federal requirements, and we must comply with them even though they may be subject to different interpretations by various courts and other governmental authorities.

**Other Requirements.** In addition to HIPAA, numerous other state and federal laws govern the collection, dissemination, use, access to and confidentiality of individually identifiable health and other information and healthcare provider information. The FTC has issued and several states have issued or are considering new regulations to require holders of certain types of personally identifiable information to implement formal policies and programs to prevent, detect and mitigate the risk of identity theft and other unauthorized access to or use of such information. Further, the U.S. Congress and a number of states have considered or are considering prohibitions or limitations on the disclosure of medical or other information to individuals or entities located outside of the United States.

### ***Government Regulation of Reimbursement***

Our customers are subject to regulation by a number of governmental agencies, including those that administer the Medicare and Medicaid programs. Accordingly, our customers are sensitive to legislative and regulatory changes in, and limitations on, the government healthcare programs and changes in reimbursement policies, processes and payment rates. During recent years, there have been numerous federal legislative and administrative actions that have affected government programs, including adjustments that have reduced or increased payments to physicians and other healthcare providers and adjustments that have affected the complexity of our work. For example, the federal healthcare reform legislation that was enacted in March 2010 may reduce reimbursement for some healthcare providers, increase reimbursement for others (including primary care physicians) and create various value and quality-based reimbursement incentives. It is possible that the federal or state governments will implement additional reductions, increases or changes in reimbursement in the future under government programs that adversely affect our customer base or our cost of providing our services. Any such changes could adversely affect our own financial condition by reducing the reimbursement rates of our customers.

### ***Fraud and Abuse Laws***

A number of federal and state laws, generally referred to as fraud and abuse laws, apply to healthcare providers, physicians and others that make, offer, seek or receive referrals or payments for products or services that may be paid for through any federal or state healthcare program and in some instances any private program. Given the breadth of these laws and regulations, they may affect our business, either directly or because they apply to our customers. These laws and regulations include:

**Anti-Kickback Laws.** There are numerous federal and state laws that govern patient referrals, physician financial relationships, and inducements to healthcare providers and patients. The federal healthcare anti-kickback law prohibits any person or entity from offering, paying, soliciting or receiving

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anything of value, directly or indirectly, for the referral of patients covered by Medicare, Medicaid and certain other federal healthcare programs or the leasing, purchasing, ordering or arranging for or recommending the lease, purchase or order of any item, good, facility or service covered by these programs. Courts have construed this anti-kickback law to mean that a financial arrangement may violate this law if any one of the purposes of an arrangement is to induce referrals of federal healthcare programs, patients or business, regardless of whether there are other legitimate purposes for the arrangement. There are several limited exclusions known as safe harbors that may protect certain arrangements from enforcement penalties although these safe harbors tend to be quite narrow. Penalties for federal anti-kickback violations can be severe, and include imprisonment, criminal fines, civil money penalties with triple damages and exclusion from participation in federal healthcare programs. Anti-kickback law violations also may give rise to a civil False Claims Act action, as described below. Many states have adopted similar prohibitions against kickbacks and other practices that are intended to induce referrals, and some of these state laws are applicable to all patients regardless of whether the patient is covered under a governmental health program or private health plan.

**False or Fraudulent Claim Laws.** There are numerous federal and state laws that forbid submission of false information or the failure to disclose information in connection with the submission and payment of provider claims for reimbursement. In some cases, these laws also forbid abuse of existing systems for such submission and payment, for example, by systematic over treatment or duplicate billing of the same services to collect increased or duplicate payments.

In particular, the federal False Claims Act, or FCA, prohibits a person from knowingly presenting or causing to be presented a civil false or fraudulent claim for payment or approval by an officer, employee or agent of the United States. The FCA also prohibits a person from knowingly making, using, or causing to be made or used a false record or statement material to such a claim. The FCA was amended on May 20, 2009 by the Fraud Enforcement and Recovery Act of 2009, or FERA. Following the FERA amendments, the FCA's "reverse false claim" provision also creates liability for persons who knowingly conceal an overpayment of government money or knowingly and improperly retain an overpayment of government funds. In addition, the federal healthcare reform legislation that was enacted in March 2010 requires providers to report and return overpayments and to explain the reason for the overpayment in writing within 60 days of the date on which the overpayment is identified, and the failure to do so is punishable under the FCA. Violations of the FCA may result in treble damages, significant monetary penalties, and other collateral consequences including, potentially, exclusion from participation in federally funded healthcare programs. The scope and implications of the recent FCA amendments have yet to be fully determined or adjudicated and as a result it is difficult to predict how future enforcement initiatives may impact our business.

In addition, under the Civil Monetary Penalty Act of 1981, the Department of Health and Human Services Office of Inspector General has the authority to impose administrative penalties and assessments against any person, including an organization or other entity, who knowingly presents, or causes to be presented, to a state or federal government employee or agent certain false or otherwise improper claims.

**Stark Law and Similar State Laws.** The Ethics in Patient Referrals Act, known as the Stark Law, prohibits certain types of referral arrangements between physicians and healthcare entities and thus potentially applies to our customers. Specifically, under the Stark Law, absent an applicable exception, a physician may not make a referral to an entity for the furnishing of designated health service (or DHS) for which payment may be made by the Medicare program if the physician (or any immediate family member) has a financial relationship with that entity. Further, an entity that furnishes DHS pursuant to a prohibited referral may not present or cause to be presented a claim or bill for such services to the Medicare program or to any other individual or entity. Violations of the statute can result in civil monetary penalties and/or exclusion from federal healthcare programs. Stark law violations also may give rise to a civil FCA action. Any such violations by, and penalties and exclusions imposed upon, our customers could adversely affect their financial condition and, in turn, could adversely affect our own financial condition.

Laws in many states similarly forbid billing based on referrals between individuals and/or entities that have various financial, ownership or other business relationships. These laws vary widely from state to state.

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### *Laws Limiting Assignment of Reimbursement Claims*

Various federal and state laws, including Medicare and Medicaid, forbid or limit assignments of claims for reimbursement from government funded programs. Some of these laws limit the manner in which business service companies may handle payments for such claims and prevent such companies from charging their provider customers on the basis of a percentage of collections or charges. We do not believe that the services we provide our customers result in an assignment of claims for the Medicare or Medicaid reimbursements for purposes of federal healthcare programs. Any determination to the contrary, however, could adversely affect our ability to be paid for the services we provide to our customers, require us to restructure the manner in which we are paid, or have further regulatory consequences.

### *Emergency Medical Treatment and Active Labor Act*

The federal Emergency Medical Treatment and Active Labor Act, or EMTALA, was adopted by the U.S. Congress in response to reports of a widespread hospital emergency room practice of "patient dumping". At the time of EMTALA's enactment, patient dumping was considered to have occurred when a hospital capable of providing the needed care sent a patient to another facility or simply turned the patient away based on such patient's inability to pay for his or her care. EMTALA imposes requirements as to the care that must be provided to anyone who seeks care at facilities providing emergency medical services. In addition, the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services has issued final regulations clarifying those areas within a hospital system that must provide emergency treatment, procedures to meet on-call requirements, as well as other requirements under EMTALA. Sanctions for failing to fulfill these requirements include exclusion from participation in the Medicare and Medicaid programs and civil monetary penalties. In addition, the law creates private civil remedies that enable an individual who suffers personal harm as a direct result of a violation of the law to sue the offending hospital for damages and equitable relief. A hospital that suffers a financial loss as a direct result of another participating hospital's violation of the law also has a similar right.

EMTALA generally applies to our customers, and we assist our customers with the intake of their patients. Although we believe that our customers' medical screening, stabilization and transfer practices are in compliance with the law and applicable regulations, we cannot be certain that governmental officials responsible for enforcing the law or others will not assert that we or our customers are in violation of these laws nor what obligations may be imposed by regulations to be issued in the future.

### *Regulation of Debt Collection Activities*

The federal Fair Debt Collection Practices Act, or FDCPA, regulates persons who regularly collect or attempt to collect, directly or indirectly, consumer debts owed or asserted to be owed to another person. Certain of our accounts receivable activities may be subject to the FDCPA. The FDCPA establishes specific guidelines and procedures that debt collectors must follow in communicating with consumer debtors, including the time, place and manner of such communications. Further, it prohibits harassment or abuse by debt collectors, including the threat of violence or criminal prosecution, obscene language or repeated telephone calls made with the intent to abuse or harass. The FDCPA also places restrictions on communications with individuals other than consumer debtors in connection with the collection of any consumer debt and sets forth specific procedures to be followed when communicating with such third parties for purposes of obtaining location information about the consumer. In addition, the FDCPA contains various notice and disclosure requirements and prohibits unfair or misleading representations by debt collectors. Finally, the FDCPA imposes certain limitations on lawsuits to collect debts against consumers.

Debt collection activities are also regulated at state level. Most states have laws regulating debt collection activities in ways that are similar to, and in some cases more stringent than, the FDCPA. In addition, some states require debt collection companies to be licensed. In all states where we operate, we believe that we currently hold all required state licenses or are pursuing a license, or are exempt from licensing.

We are also subject to the Fair Credit Reporting Act, or FCRA, which regulates consumer credit reporting and which may impose liability on us to the extent that the adverse credit information reported on a consumer

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to a credit bureau is false or inaccurate. State law, to the extent it is not preempted by the FCRA, may also impose restrictions or liability on us with respect to reporting adverse credit information.

The FTC has the authority to investigate consumer complaints relating to the FDCPA and the FCRA, and to initiate or recommend enforcement actions, including actions to seek monetary penalties. State officials typically have authority to enforce corresponding state laws. In addition, affected consumers may bring suits, including class action suits, to seek monetary remedies (including statutory damages) for violations of the federal and state provisions discussed above.

### ***Regulation of Credit Card Activities***

We accept payments by credit cards from patients of our customers. Various federal and state laws impose privacy and information security laws and regulations with respect to the use of credit cards. If we fail to comply with these laws and regulations or experience a credit card security breach, our reputation could be damaged, possibly resulting in lost future business, and we could be subjected to additional legal or financial risk as a result of non-compliance.

### ***Foreign Regulations***

Our operations in India are subject to additional regulations by the government of India. These include Indian federal and local corporation requirements, restrictions on exchange of funds, employment-related laws and qualification for tax status.

## **Intellectual Property**

We rely upon a combination of patent, trademark, copyright and trade secret laws and contractual terms and conditions to protect our intellectual property rights, and have sought patent protection for aspects of our key innovations.

We have been issued one U.S. patent, which expires in 2028, and filed six additional U.S. patent applications aimed at protecting the four domains of our AHtoAccess software suite: patient access, improving best possible, follow-up and measurement. See “Business — Technology — Proprietary Software Suite” for more information. Legal standards relating to the validity, enforceability and scope of protection of patents can be uncertain. We do not know whether any of our pending patent applications will result in the issuance of patents or whether the examination process will require us to narrow our claims. Our patent applications may not result in the grant of patents with the scope of the claims that we seek, if at all, or the scope of the granted claims may not be sufficiently broad to protect our products and technology. Our one issued patent or any patents that may be granted in the future from pending or future applications may be opposed, contested, circumvented, designed around by a third party or found to be invalid or unenforceable. Third parties may develop technologies that are similar or superior to our proprietary technologies, duplicate or otherwise obtain and use our proprietary technologies or design around patents owned or licensed by us. If our technology is found to infringe any patent or other intellectual property right held by a third party, we could be prevented from providing our service offerings and subject us to significant damage awards.

We also rely in some circumstances on trade secrets to protect our technology. We control access to and the use of our application capabilities through a combination of internal and external controls, including contractual protections with employees, customers, contractors and business partners. We license some of our software through agreements that impose specific restrictions on customers’ ability to use the software, such as prohibiting reverse engineering and limiting the use of copies. We also require employees and contractors to sign non-disclosure agreements and invention assignment agreements to give us ownership of intellectual property developed in the course of working for us.

On occasion, we incorporate third-party commercial or open source software products into our technology platform. Although we prefer to develop our own technology, we periodically employ third-party software in order to simplify our development and maintenance efforts, provide a “commodity” capability, support our own technology infrastructure or test a new capability.

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### **Employees**

As of December 31, 2010, we had 1,991 full-time employees, including 255 engaged in technology development and deployment, as well as 231 part-time employees. None of our employees is represented by a labor union and we consider our current employee relations to be good.

Our operations employees are required to participate in our “operator academy” and “revenue cycle academy”, consisting of multiple training sessions each year. Our ongoing training and executive learning programs are modeled after the practices of companies that we believe have reputations for service excellence. In addition, all of our employees undergo mandatory HIPAA training.

As of December 31, 2010, pursuant to managed service contracts, we also managed approximately 8,200 revenue cycle staff persons who are employed by our customers. We have the right to control and direct the work activities of these staff persons and are responsible for paying their compensation out of the base fees paid to us by our customers, but these staff persons are considered employees of our customers for all purposes.

### **Corporate Information**

We were incorporated in Delaware under the name Healthcare Services, Inc. in July 2003 and changed our name to Accretive Health, Inc. in August 2009. Our principal executive offices are located at 401 North Michigan Avenue, Suite 2700, Chicago, Illinois 60611, and our telephone number is (312) 324-7820.

### **Information availability**

Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to those reports are available free of charge on our website at [www.accretivehealth.com](http://www.accretivehealth.com) under the “Investor Relations” caption as soon as reasonably practicable after such material is electronically filed with, or furnished to, the Securities and Exchange Commission. The content on any website referred to in this Annual Report on Form 10-K is not incorporated by reference into this report, unless expressly noted otherwise.

### **Item 1A. Risk Factors**

#### **Risks Related to Our Business and Industry**

*We may not be able to maintain or increase our profitability, and our recent growth rates may not be indicative of our future growth rates.*

We have been profitable on an annual basis only since the year ended December 31, 2007, and we incurred net losses in the quarters ended March 31, 2007, December 31, 2007, March 31, 2008, December 31, 2008 and March 31, 2009. We may not succeed in maintaining our profitability on an annual basis and could incur quarterly or annual losses in future periods. We expect to incur additional operating expenses associated with being a public company and we intend to continue to increase our operating expenses as we grow our business. We also expect to continue to make investments in our proprietary technology applications, sales and marketing, infrastructure, facilities and other resources as we expand our operations, thus incurring additional costs. If our revenue does not increase to offset these increases in costs, our operating results would be negatively affected. You should not consider our historic revenue and net income growth rates as indicative of future growth rates. Accordingly, we cannot assure you that we will be able to maintain or increase our profitability in the future. Each of the risks described in this “Risk Factors” section, as well as other factors, may affect our future operating results and profitability.

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*Hospitals affiliated with Ascension Health currently account for a majority of our net services revenue, and we have several customers that have each accounted for 10% or more of our net services revenue in past fiscal periods. The termination of our master services agreement with Ascension Health, or any significant loss of business from our large customers, would have a material adverse effect on our business, results of operations and financial condition.*

We are party to a master services agreement with Ascension Health pursuant to which we provide services to its affiliated hospitals that execute separate managed service contracts with us. Hospitals affiliated with Ascension Health have accounted for a majority of our net services revenue each year since our formation. In the years ended December 31, 2008, 2009 and 2010, aggregate revenue from hospitals affiliated with Ascension Health represented 70.7%, 60.3% and 50.7% of our net services revenue in such periods. In some fiscal periods, individual hospitals affiliated with Ascension Health have each accounted for 10% or more of our total net services revenue. For example, in the years ended December 31, 2009 and 2010, revenue from St. John Health (an affiliate of Ascension Health) was \$66.5 million and \$67.5 million, respectively, equal to 13.0% and 11.1%, respectively, of our total net services revenue. In addition, another customer, which is not affiliated with Ascension Health, accounted for 10.6% of our total net services revenue in the year ended December 31, 2008 but less than 10% of our total net services revenue in the years ended December 31, 2009 and 2010. Additionally, Henry Ford Health System, which is not affiliated with Ascension Health and with which we entered into a managed service contract in 2009, accounted for 11.3% of our total net services revenue in the year ended December 31, 2010. Furthermore, Fairview Health Services, which is not affiliated with Ascension Health and with which we entered into a managed service contract in 2010, accounted for 10.7% of our total net services revenue in the year ended December 31, 2010.

All of our managed service contracts with hospitals affiliated with Ascension Health will expire on December 31, 2012 unless renewed. Pursuant to our master services agreement with Ascension Health and our managed service contracts with hospitals affiliated with Ascension Health, our fees are subject to adjustment in the event quarterly cash collections at these hospitals deteriorate materially after we take over revenue cycle management operations. While these adjustments have never been triggered, if they were, our future fees from hospitals affiliated with Ascension Health would be reduced. In addition, any of our other customers, including hospitals affiliated with Ascension Health, can elect not to renew their managed service contracts with us upon expiration. We intend to seek renewal of all managed service contracts with our customers, but cannot assure you that all of them will be renewed or that the terms upon which they may be renewed will be as favorable to us as the terms of the initial managed service contracts.

Our inability to renew the managed service contracts with hospitals affiliated with Ascension Health, the termination of our master services agreement with Ascension Health, the loss of any of our other large customers or their failure to renew their managed service contracts with us upon expiration, or a reduction in the fees for our services for these customers would have a material adverse effect on our business, results of operations and financial condition.

*Our master services agreement with Ascension Health requires us to offer to Ascension Health's affiliated hospitals service fees that are at least as low as the fees we charge any other similarly situated customer receiving comparable services at comparable volumes.*

Our master services agreement with Ascension Health requires us to offer to Ascension Health's affiliated hospitals fees for our services that are at least as low as the fees we charge any other similarly-situated customer receiving comparable services at comparable volumes. If we were to offer another similarly-situated customer receiving a comparable volume of comparable services fees that are lower than the fees paid by hospitals affiliated with Ascension Health, we would be obligated to offer such lower fees to hospitals affiliated with Ascension Health, which could have a material adverse effect on our results of operations and financial condition.

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***Our agreements with hospitals affiliated with Ascension Health and with some other customers include provisions that could impede or delay our ability to enter into managed service contracts with new customers.***

Under the terms of our master services agreement with Ascension Health, we are required to consult with Ascension Health's affiliated hospitals before undertaking services for competitors specified by them in the managed service contracts they execute with us. As a result, before we can begin to provide services to a specified competitor, we are required to inform and discuss the situation with the Ascension Health affiliated hospital that specified the competitor but are not required to obtain the consent of such hospital. In addition, we are required to obtain the consent of one customer not affiliated with Ascension Health before providing services to competitors specified by such customer. In another instance, our managed service contract with one other customer not affiliated with Ascension Health requires us to consult with such customer before providing services to competitors specified by such customer. The obligations described above could impede or delay our ability to enter into managed service contracts with new customers.

***The markets for our revenue cycle management and quality and total cost of care services may develop more slowly than we expect, which could adversely affect our revenue and our ability to maintain or increase our profitability.***

Our success depends, in part, on the willingness of hospitals, physicians and other healthcare providers to implement integrated solutions that span the entire revenue cycle, which encompasses patient registration, insurance and benefit verification, medical treatment documentation and coding, bill preparation and collections. Our success also depends on healthcare providers' willingness to move away from traditional fee-for-service payment systems and toward accountable care organizations and similar initiatives. Some hospitals may be reluctant or unwilling to implement our solutions for a number of reasons, including failure to perceive the need for improved revenue cycle operations and quality and total cost of care services, and lack of knowledge about the potential benefits our solutions provide.

Even if potential customers recognize the need to improve revenue cycle operations and to more effectively manage the health of defined patient populations, they may not select solutions such as ours because they previously have made investments in internally developed solutions and choose to continue to rely on their own internal resources. As a result, the markets for integrated, end-to-end revenue cycle and quality and total cost of care solutions may develop more slowly than we expect, which could adversely affect our revenue and our ability to maintain or increase our profitability.

***We operate in a highly competitive industry, and our current or future competitors may be able to compete more effectively than we do, which could have a material adverse effect on our business, revenue, growth rates and market share.***

The market for revenue cycle management solutions is highly competitive and we expect competition to intensify in the future. We face competition from a steady stream of new entrants, including the internal revenue cycle management staff of hospitals, as described above, and external participants. External participants that are our competitors in the revenue cycle market include software vendors and other technology-supported revenue cycle management business process outsourcing companies; traditional consultants; and information technology outsourcing. These types of external participants also compete with us in the field of quality and total cost of care. In addition, the commercial payor community has historically attempted to provide information or services that are intended to assist providers in reducing the total cost of medical care. They could attempt to develop similar programs again. Our competitors may be able to respond more quickly and effectively than we can to new or changing opportunities, technologies, standards, regulations or customer requirements. We may not be able to compete successfully with these companies, and these or other competitors may introduce technologies or services that render our technologies or services obsolete or less marketable. Even if our technologies and services are more effective than the offerings of our competitors, current or potential customers might prefer competitive technologies or services to our technologies and services. Increased competition is likely to result in pricing pressures, which could negatively impact our margins, growth rate or market share.

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### *If we are unable to retain our existing customers, our financial condition will suffer.*

Our success depends in part upon the retention of our customers, particularly Ascension Health and its affiliated hospitals. We derive our net services revenue primarily from managed service contracts pursuant to which we receive base fees and incentive payments. Customers can elect not to renew their managed service contracts with us upon expiration. If a managed service contract is not renewed or is terminated for any reason, including for example, if we are found to be in violation of any federal or state fraud and abuse laws or excluded from participating in federal and state healthcare programs such as Medicare and Medicaid, we will not receive the payments we would have otherwise received over the life of contract. In addition, financial issues or other changes in customer circumstances, such as a customer change in control, may cause us or the customer to seek to modify or terminate a managed service contract, and either we or the customer may generally terminate a contract for material uncured breach by the other. If we breach a managed service contract or fail to perform in accordance with contractual service levels, we may also be liable to the customer for damages. Any of these events could adversely affect our business, financial condition, operating results and cash flows.

### *We face a variable selling cycle to secure new revenue cycle and quality and total cost of care managed service contracts, making it difficult to predict the timing of specific new customer relationships.*

We face a variable selling cycle, typically spanning six to twelve months, to secure a new managed service contract. Even if we succeed in developing a relationship with a potential new customer, we may not be successful in entering into a managed service contract with that customer. In addition, we cannot accurately predict the timing of entering into managed service contracts with new customers due to the complex procurement decision processes of most healthcare providers, which often involves high-level or committee approvals. Consequently, we have only a limited ability to predict the timing of specific new customer relationships.

### *Delayed or unsuccessful implementation of our technologies or services with our customers or implementation costs that exceed our expectations may harm our financial results.*

To implement our solutions, we utilize the customer's existing management and staff and layer our proprietary technology applications on top of the customer's existing patient accounting and clinical systems. Each customer's situation is different, and unanticipated difficulties and delays may arise. If the implementation process is not executed successfully or is delayed, our relationship with the customer may be adversely affected and our results of operations could suffer. Implementation of our solutions also requires us to integrate our own employees into the customer's operations. The customer's circumstances may require us to devote a larger number of our employees than anticipated, which could increase our costs and harm our financial results.

### *Our quarterly results of operations may fluctuate as a result of factors that may impact our incentive and base fees, some of which may be outside of our control.*

We recognize base fee revenue on a straight-line basis over the life of the managed service contract. Base fees for contracts which are received in advance of services delivered are classified as deferred revenue until services have been provided. Our managed service contracts generally allow for adjustments to the base fee. Adjustments typically occur at 90, 180 or 360 days after the contract commences, but can also occur at subsequent dates as a result of factors including changes to the scope of operations and internal and external audits. In addition, our fees from hospitals affiliated with Ascension Health are subject to adjustment in the event quarterly cash collections at these hospitals deteriorate materially after we take over revenue cycle management operations. While these adjustments have never been triggered, if they were, our future fees from hospitals affiliated with Ascension Health would be reduced. Further, estimates of the incentive payments we have earned from providing services to customers in prior periods could change because the laws, regulations, instructions, payor contracts and rule interpretations governing how our customers receive payments from payors are complex and change frequently. Any such change in estimates could be material. The timing of such adjustments is often dependent on factors outside of our control and may result in material increases or